ing a run of ventricular premature systoles or ventricular fibrillation.

As to the dermal reactions, apparently they are a matter of idiosyncrasy. In two of five patients with this reaction, the complaint was noted in both the carotid sinus and stellate ganglion areas. It also seemed that once the burning sensation was evoked, the threshold was further lowered in the individual, and it was surmised that anticipation may be a factor in discomfort at dosages the patient might ordinarily tolerate.

The occurrence of cough in several cases when the carotid sinus area was sounded leads us to believe that the cough reflex is stimulated via the superior laryngeal nerve. If this assumption is correct, it implies that ultrasound can stimulate a peripheral nerve.

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Medial Epicondylitis

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THE GREAT DEAL that has been written about the condition known as "tennis elbow" or lateral epicondylitis[1,2] contrasts with the paucity of literature relating to the subject of medial epicondylitis.[3] The purpose of this communication is to report observations in a series of recent cases of this condition and to review the subject.

"Tennis elbow" is thought to be brought about by inflammation of the periosteum of the lateral condyle or a partial tear of the conjoined tendon of the extensor muscles. It is believed that a similar condition sometimes occurs on the medial side of the elbow involving the medial epicondyle and the conjoined tendon of the flexor group. The flexor group is composed of the pronator teres, the flexor carpi radialis, the palmaris longus and the flexor carpi ulnaris. Both these conditions are caused by constant minor trauma and tension of the tendon attachment to the epicondyles.

The clinical features observed in the 11 cases that are the basis of this report were:

The patient usually complained of pain about the elbow with radiation up and down the arm.

Decided local tenderness was noted over the medial epicondyle and the conjoined tendon of the flexor group, without evidence of swelling or erythema.

Pain was evoked by resisted flexion of the wrist and by pronation.

Patients noticed weakness of grip.

In no case was abnormality of blood or urine associated with the disease. The elbow in all cases was roentgenographically normal.

TREATMENT

In the present series the pain and symptoms subsided when the following treatment was given: First local injection of the epicondyle and the conjoined tendon with 2 cc. of one per cent lidocaine hydrochloride (Xylocaine®) and 25 mg. of hydrocortisone in the same syringe, making sure that both the tendon and the periosteum were so treated; then warm soaks of the elbow on the following day. In a few cases it was necessary to apply a volar mold for several weeks with the wrist in the position of function, the mold being removed daily for hot soaks of the elbow and then reapplied with an Ace bandage.

In the more severe cases—those that do not respond to conservative therapy—surgical operation consisting of stripping the tendon from the epicondyle may be indicated.

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